



Office of Workers Compensation Program

ICPA Coordinator

Kay Edenburn

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FECA

Federal Employees' Compensation Act

- **Provides compensation benefits to civilian employees and National Guard Technicians, both permanent and temporary of the U.S. federal government for disability due to traumatic injury or disease or illness in performance of duties**
- **Provides payment of benefits to dependents for work-related death of an employee as a result of traumatic injury or occupational disease/illness**
- **FECA provides exclusive remedy for work-related injury, disease, or death**



Office of Workers Compensation Program

DOL

Department of Labor

- Administers OWCP for all federal agencies
- Accepts or denies claims
- Adjudicates all claims
- Provides for payment of claims



Office of Workers Compensation Program

ICPA Coordinator Injury Compensation Program Administrator

- Assists in submission of claims
- Acts as the liaison between employee, supervisor and the DOL
- Informs employees and supervisors of program benefits and requirements



Office of Workers Compensation Program

RESPONSIBILITIES Supervisors

- **Contact ICPA immediately of injured employee and request CA-16 Authorized for Examination And/Or Treatment**
- Complete and submit forms in timely manner through Electronic Data Interchange (EDI)
 - CA-1 and CA-2 within ten days of receipt
 - CA-7 within five days of receipt
- Encourage safe work habits and conditions and enforce safety regulations
- Advise employees on rights and responsibilities
- Encourage reporting of incidents
- Publicize the OWCP and employees' responsibilities under it
- Continue pay in traumatic injuries



Office of Workers Compensation Program

RESPONSIBILITIES Supervisors

- Assist employees in returning to work
- Represent the agency's interest
- Challenge questionable claims
- Keep in contact with employee
- Help manage compensation costs
- Coordinate return to work with doctor and accommodate "light duty" work when able
- Coordinate personnel actions with HRO
- Track Injured Employee's Medical Status and availability for work
- Investigate incidents; obtain statements; controvert questionable claims



Office of Workers Compensation Program

RESPONSIBILITIES Employees

- Observe health and safety regulations
- Report potential and actual health, safety, and fire hazards
- Report all injuries to supervisor
- Obtain medical status reports from physician(s)
- Provide medical provider with Claim Number
- Cooperate with light duty placement
- It is the claimant responsibility to monitor his/her own claim, just as he/she would if it were an insurance claim
- Check the status on their bills through ACS-Web Billing Process Portal



Office of Workers Compensation Program

The **FIVE** provisions for filing a claim

- **EMPLOYMENT**
- **TIMELINESS**
- **PERFORMANCE
OF DUTY**
- **FACT OF INJURY**
 - **CAUSAL
RELATIONSHIP**



Office of Workers Compensation Program

The **FIVE** provisions for filing a claim

EMPLOYMENT

Must be a Federal Technician at the time of injury

TIMELINESS

Notice of injury/disease must be filed within statutory time (3 years from the date of incident or exposure, or the date of awareness of a work relationship)



Office of Workers Compensation Program

The **FIVE** provisions for filing a claim

PERFORMANCE OF DUTY

Must have been in performance of official duties at time of
incident

COVERED

- ◆ Industrial premises
- ▢ Performing assigned duties
- ▢ Engaged in activities which are reasonable incidents of employment
- ▢ TDY
- ▢ Physical Training

NOT

COVERED

- ▢ Horseplay/assault
- ▢ Recreational injuries
- ▢ Travel to and from work w/fixed place of employee and fixed hours of work is **NOT** covered



Office of Workers Compensation Program

The **FIVE** provisions for filing a claim

FACT OF INJURY

Must be able to identify the factors which caused in injury/disability

- **FACTUAL** – Did the employee experience the incident?
- **MEDICAL** – Does the employee have a diagnosed condition as a result of the incident?

CAUSAL RELATIONSHIP

Must prove federal employment cause – based on medical evidence from a physician who performed examination or provided treatment



Office of Workers Compensation Program

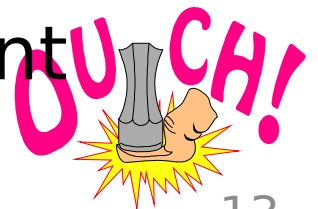
The **TWO** types of injuries

- **TRAUMATIC INJURY**

- **OCCUPATIONAL
DISEASE/ILLNESS**

TRAUMATIC INJURY

- A wound or other condition of the body caused by external force, including stress or strain.
- The injury must be identifiable by time and place of occurrence, and the member or function of body affected, and must be caused by a specific event or incident within a single day or work shift.



OCCUPATIONAL DISEASE/ILLNESS

A condition produced by -

- systemic infections;
- continued or repeated stress or strain;
- exposure to toxins, poisons, fumes, etc.;
- other exposure to conditions of the work environment for two or more shifts.



DOCUMENTATION

For Traumatic Injury Cases:

- CA1 Federal Employee's Notice of Traumatic Injury and Claim for Continuation Pay/Compensation (electronically)
- CA 7 Claim for Compensation (electronically)
- CA 7a Time Analysis Form
- CA 7b Leave Buy Back Worksheet
- CA16 Authorization for Examination And/Or Treatment
- CA17 Duty Status Report
- CA 20 Attending Physician's Report
- CA 2 Notice of Recurrence

DOCUMENTATION **For Occupational** **Disease/Illness:**

- CA2 Notice of Occupational Disease
- CA35 Series Specialized Occupational Disease Checklist
(It is the employee responsibility to gather documentation)
- CA20 Attending Physician's Report
- CA2a

OWCP Benefits

- Medical expenses (fee schedule)
- First aid expenses
- Rehabilitation
- Chiropractic care (limited)
(manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist)
- Assisted Reemployment Program
(Therapeutic & Vocational Rehabilitation)

OWCP Benefits (Con't)

- Early nurse intervention
- Continuation of Pay (COP)
- Compensation for Lost Wages
- Scheduled Benefits
- Permanent Total Disability
- Death Benefits



Office of Workers Compensation Program

CA Form 16

This form is only available from your ICPA (Injury Compensation Program Administrator)

PURPOSE OF CA-16

Form CA-16 guarantees payment to the original treating physician (or any physician to whom the original treating physician refers the employee) for 60 days from date of issuance, unless OWCP terminates this authority at an earlier date.

EMERGENCY

In an emergency, where there is no time to complete CA-16, The supervisor may authorize medical treatment verbally and then request CA-16 from ICPA within 48 hours. The supervisor will then forward the CA-16 and other documentation to the medical facility and provide the IPCA with completed documentation.

NOT ALLOWED

Retroactive issuance of the CA-16 is not allowed under any other circumstance. Issuing of CA-16 if more than a week has passed since the injury, is not allowed.



Office of Workers Compensation Program

**If it is a life or death situation
dial 911
for the Air National Guard base 117 or 911**

Basic Information needed to issue CA Form 16

- Employee's Last Name, First Name, MI
 - Date of injury
 - Employee's Occupation
 - Brief description of injury

I will then email approved CA Form 16 to include page 2 and CA Form 17 with all instructions (Supervisor's will insure that blocks 8 & 9 on page 1 of CA Form 16 are completed and given to employee).

If I am TDY or on vacation contact COL Burckle, MAJ Lock or Mr. Groves my District Manager.

or email: **NGUTHRO-HRS(OWCP)**

Office of Workers Compensation Program

Form CA-16 Packet

Authorization for Examination And/Or Treatment The following request for information is authorized by law (5 USC §101 et. seq.). Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and OMB Cr. No. A-108.		U.S. Department of Labor Employment Standards Administration Office of Workers' Compensation Programs OMB No.: 1215-0103 Expires: 10-31-99
PART A - AUTHORIZATION 1. Name and Address of the Medical Facility or Physician Authorized to Provide the Medical Service:		
2. Employee's Name (last, first, middle) DOE, JOHN C.	3. Date of Injury (mo., day, yr.) 01/22/2011	4. Occupation Surf Maint Coord
5. Description of Injury or Disease: While playing basketball an authorized physical activity, I jump for the ball and rolled left ankle		
6. You are authorized to provide medical care for the employee for a period of up to sixty days from the date shown in item 11, subject to the condition stated in item A, and to the condition indicated either 1 or 2, in item B.		
A. Your signature in item 36 of Part B certifies your agreement that all fees for services shall not exceed the maximum allowable fee established by OWCP and that payment by OWCP will be accepted as payment in full for said services.		
B. <input type="checkbox"/> 1. Furnish office and/or hospital treatment as medically necessary for the effects of this injury. Any surgery other than emergency must have prior OWCP approval.		
<input type="checkbox"/> 2. There is doubt whether the employee's condition is caused by an injury sustained in the performance of duty, or is otherwise related to the employment. You are authorized to examine the employee using indicated non-surgical diagnostic studies, and promptly advise the employee whether you believe the condition is due to the alleged injury or to any circumstances of the employment. Under your advice you may provide necessary conservative treatment if you believe the condition may be to the injury sustained in the employment.		
7. If a Disease or Illness is Involved, OWCP Approval for Issuing Authorization was Obtained from: (Type Name and Title of OWCP Official) JANE M. DOE IPCA Coordinator	8. Signature of Authorizing Official: _____ 9. Name and Title of Authorizing Official (Print Clearly) Supervisor's Signature Supervisor's Title	
10. Local Employing Agency Telephone Number: 801.432.4243	11. Date (mo., day, year) 01/22/2011	
12. Send one copy of your report: (Fill in remainder of address) U.S. DEPARTMENT OF LABOR Employment Standards Administration Office of Workers' Compensation Programs DFEC Central Mailroom P.O. Box 8300 London, KY 40742		
Department of Agency Utah National Guard (ARMY or AIR) Bureau or Office HRO-ICPA Local Address (including ZIP Code) Headquarters Utah National Guard 12953 South Minuteman Drive Draper, UT 84020-1776		
Public Burden Statement We estimate that it will take an average of 30 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Information Policy, U.S. Department of Labor, Room N1901, 200 Constitution Avenue, N.W., Washington, D.C. 20210, and to the Office of Management and Budget, Paperwork Reduction Project (1215-0103), Washington, D.C. 20503.		
DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES		

14. Employee's Name (last, first, middle) DOE, JOHN C.	
16. What History of Injury or Disease Did Employee Give You? 18. Is there any History or Evidence of Concurrent or Pre-existing Injury, Disease, or Physical Impairment? (If yes, please describe) <input type="checkbox"/> Yes <input type="checkbox"/> No	
17. What are Your Findings? (include results of X-rays, laboratory tests, etc.) 18. What is Your Diagnosis? 19. Do You Believe the Condition Found was Caused or Aggravated by the Employment Activity Described? (Please explain your answer if there is doubt) <input type="checkbox"/> Yes <input type="checkbox"/> No	
20. Did Injury Require Hospitalization? If yes, date of admission (mo., day, year) Date of discharge (mo., day, year)	21. Is Additional Hospitalization Required? <input type="checkbox"/> Yes <input type="checkbox"/> No
22. Surgery (if any, describe type)	23. Date Surgery Performed (mo., day, year)
24. What (Other) Type of Treatment Did You Provide?	25. What Permanent Effects, if Any, Do You Anticipate?
26. Date of First Examination (mo., day, year)	27. Date(s) of Treatment (mo., day, year)
28. Period of Disability (mo., day, year) (If termination date unknown, indicate) Total Disability: From _____ To _____ Partial Disability: From _____ To _____	29. Is Employee Able to Resume? <input type="checkbox"/> Light Work <input type="checkbox"/> Regular Work Date: _____
31. If Employee is Able to Resume Work, Has He/She Been Advised? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Furnish Date Advised	
32. If Employee is Able to Resume Only Light Work, Indicate the Extent of Physical Limitations and the Type of Work that Could Reasonably be Performed with these Limitations.	
33. General Remarks and Recommendations for Future Care, if Indicated. If you have made a Referral to Another Physician or to a Medical Facility, Provide Name and Address.	
34. Do You Specialize? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, state specialty)	
35. SIGNATURE OF PHYSICIAN: I certify that all the statements in response to the questions asked in Part B of this form are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.	36. Address (No., Street, City, State, Zip Code)
37. Tax Identification Number	38. Date of Report

Only a Medical Doctor (M.D.) signature is acceptable

MEDICAL BILL: Charges for your services should be presented to the AMA standard "Health Insurance Claim Form" (AMA OP 407/408/409; OWCP-1500a, or HCFA 1500). Service must be itemized by Current Procedural Terminology Code (CPT 4) and the form must be signed.

Office of Workers Compensation Program

Form CA-16 Packet (Con't)

Duty Status Report

U.S. Department of Labor
Office of Workers' Compensation Programs

Reset Print

This form is provided for the purpose of obtaining a duty status report for the employee named below. This request does not constitute authorization for payment of medical expense by the Department of Labor, nor does it invalidate any previous authorization issued in this case. This request for information is authorized by law (5 USC 8101 et seq.) and is required to obtain or retain a benefit. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No. 1240-0048
Expires: 05-30-2011
OWCP File Number (if known)

SIDE A - Supervisor: Complete this side and refer to physician

1. Employee's Name (Last, first, middle)
DOE, JOHN C

2. Date of Injury (Month, day, yr)
01/23/2011

3. Social Security No.
123-45-6789

4. Occupation
SURFACE MAINTENANCE COORDINATOR

5. Describe How the Injury Occurred and State Parts of the Body Affected
While playing basketball a authorized Physical Activity, jumped and rolled right ankle.

6. The Employee Works
Hours Per Day 10.00 Days Per Week 4.00

7. Specify the Usual Work Requirements of the Employee. Check Whether Employee Performs These Tasks or is Exposed Continuously or Intermittently, and Give Number of Hours.

Activity	Continuous	Intermittent	hrs.	hrs.	Hrs Per Day
a. Lifting/Carrying: State Max Wt.	<input type="checkbox"/>	<input type="checkbox"/>			Hrs Per Day
b. Sitting	<input type="checkbox"/>	<input type="checkbox"/>			Hrs Per Day
c. Standing	<input type="checkbox"/>	<input type="checkbox"/>			Hrs Per Day
d. Walking	<input type="checkbox"/>	<input type="checkbox"/>			Hrs Per Day
e. Climbing	<input type="checkbox"/>	<input type="checkbox"/>			Hrs Per Day
f. Kneeling	<input type="checkbox"/>	<input type="checkbox"/>			Hrs Per Day
g. Bending/Stooping	<input type="checkbox"/>	<input type="checkbox"/>			Hrs Per Day
h. Twisting	<input type="checkbox"/>	<input type="checkbox"/>			Hrs Per Day
i. Pulling/Pushing	<input type="checkbox"/>	<input type="checkbox"/>			Hrs Per Day
j. Simple Grasping	<input type="checkbox"/>	<input type="checkbox"/>			Hrs Per Day
k. Fine Manipulation (includes keypunching)	<input type="checkbox"/>	<input type="checkbox"/>			Hrs Per Day
l. Reaching above Shoulder	<input type="checkbox"/>	<input type="checkbox"/>			Hrs Per Day
m. Driving a Vehicle (Specify)	<input type="checkbox"/>	<input type="checkbox"/>			Hrs Per Day
n. Operating Machinery (Specify)	<input type="checkbox"/>	<input type="checkbox"/>			Hrs Per Day
o. Temp. Extremes	<input type="checkbox"/>	<input type="checkbox"/>			Hrs Per Day
p. High Humidity	<input type="checkbox"/>	<input type="checkbox"/>			Hrs Per Day
q. Chemicals, Solvents, etc. (Identify)	<input type="checkbox"/>	<input type="checkbox"/>			Hrs Per Day
r. Fumes/Dust (Identify)	<input type="checkbox"/>	<input type="checkbox"/>			Hrs Per Day
s. Noise (Give dBA)	<input type="checkbox"/>	<input type="checkbox"/>			Hrs Per Day
t. Other (Describe)	<input type="checkbox"/>	<input type="checkbox"/>			Hrs Per Day

14. Are Interpersonal Relations Affected Because of a Neuropsychiatric Condition? (e.g. Ability to Give or Take Supervision, Meet Deadlines, etc.)
☐ Yes ☐ No (Describe)

15. Date of Examination
16. Date of Next Appointment

17. Specialty
18. Tax Identification Number

19. Physician's Signature
20. Date

Form CA-17
Rev. Jan. 1997

INSTRUCTIONS FOR AUTHORIZING OFFICIAL FOR COMPLETION OF PART A

SELECTION OF PHYSICIAN

- A Federal employee injured by accident while in the performance of duty has the initial right to select a physician of his/her choice to provide necessary treatment. The supervisor shall immediately authorize examination and appropriate medical care by use of Form CA-16 issued to either a United States medical officer/hospital or any duly qualified physician/hospital of the employee's choice.

If the employee elects to be treated by a private physician, a copy of the American Medical Association standards billing form (AMA OP 407/408/409; OWCP-1500a) should be supplied together with Form CA-16.

A physician who is debarred from the FECA program as provided at 20 CFR 10.450-457 may not be authorized to examine or treat an injured Federal employee.

Generally, 25 miles from the place of injury, employing agency, or the employee's home is a reasonable distance to travel for medical care; however, other pertinent factors must also be considered.

PERIOD OF AUTHORIZATION

- Form CA-16 is valid for up to 90 days from date of issuance, and may be terminated earlier upon written notice from OWCP to the provider. It should not be used to authorize a change of physicians or a change in the choice is exercised by the employee.

FEDERAL MEDICAL FACILITIES

- U.S. medical facilities include Public Health Service, Military, or VA hospitals. Federal health care facilities (health units) established under 5 USC 7901 are not U.S. medical facilities as used herein (see 20 CFR 10.400).

DEFINITION OF INJURY

The term "injury" includes damage to or destruction of medical braces, artificial limbs and other prosthetic devices. Eyeglasses and hearing aids are included only if the damages were incidental to a personal injury which required medical services. Treatment for illness or disease should not be authorized unless approval is first obtained from OWCP.

DEFINITION OF PHYSICIAN

- The term "physician" includes doctors of medicine (MD), surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners within the scope of their practice as defined by State law. The reimbursable services of chiropractors under the FECA are limited by statute to physical examination, related laboratory tests and X-rays to diagnose a subluxation of the spine; and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

FORM COMPLETION

- Part A shall be completed in full by the authorizing official. The authorization is not valid unless the name and address of the physician or hospital is entered in item 1 and the signature of the authorizing official appears in item B. Check B1 or B2 or item 6, whichever is appropriate. In case of illness or disease, only Box B2 may be checked.

Show the address of the proper OWCP Office in item 12. Send original and one copy of Form CA-16 to the medical officer or physician. If issued for illness or disease, a copy must also be sent to OWCP.

ADDITIONAL INFORMATION

- See 20 CFR and/or Chapter 810, Federal Personnel Manual (FPM).

Information for Physician - See Reverse Side

Office of Workers Compensation Program

Form CA-16 Packet (Con't)

INSTRUCTIONS FOR PHYSICIAN

YOUR AUTHORIZATION

- Please read Part A of Form CA-16. You are authorized to examine and provide treatment for the injury or disease described in item 5, for a period of not more than 60 days from the date of issuance, subject to the conditions in item 6. A physician who is debarred from the FECA program as provided at 20 CFR 10.450-457 may not be authorized to examine or treat an injured Federal employee. Authorization may be terminated earlier upon written notice from OWCP. For extension of the authorization to treat beyond the 60 day period, apply to the office shown in Part A, item 12.

USE OF CONSULTANTS AND HOSPITALS

- You may utilize consultants, laboratories and local hospitals, if needed. Authorize semi-private accommodations unless a private room is medically necessary. Ancillary treatment may be provided to a hospitalized employee as necessary.

REPORTS

- After examination, complete items 14 through 38, of Part B, and send your report, together with any additional narrative or explanatory material, to the address listed in Part A, item 12. If the employee sustained a traumatic injury and is disabled for work, reports on Form CA-17, "Duty Status Report" may be required. If the employee is employed during the first 45 days of disability, if disability continues beyond 45 days, monthly reports should be submitted. Reports from all consultants are required. Delay in submitting medical reports may delay payment of benefits.

RELEASE OF RECORDS

- Injury reports are official records of OWCP. They shall not be released to anyone nor may they be altered or made of them without the approval of OWCP.

BILLING FOR SERVICES

- OWCP requires that charges be itemized using the AMA standard "Health Insurance Claim System" (AMA OP 407/408/409; OWCP-1500, or HCFA-1500). Each procedure must be identified, in Column 24 C of the form, by the applicable Current Procedural Terminology (4th edition) Code (CPT 4). A copy of the form may be supplied by the employee at the time treatment is sought.

- Payment for chiropractic services is limited to charges for physical examinations, related laboratory tests, and X-rays to diagnose a subluxation of the spine; and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

TAX IDENTIFICATION NUMBER

- The provider's Tax Identification Number (TIN) is an important identifier in the OWCP system. To speed processing and to reduce inaccuracy of payment, the provider's TIN (Employer Identification Number or SSN) should be shown on all reports and billings submitted to OWCP. If possible, providers should decide on a single TIN - either corporate or personal - which is used consistently on OWCP claims.

ADDITIONAL INFORMATION

- Contact the OWCP shown in item 12 of Part A.

Please Remove These Instructions Before Submitting Your Report.



Gary R. Herbert
Governor
Major General Brian L. Tarbet
The Adjutant General

State of Utah UTAH NATIONAL GUARD

12953 MINUTEMAN DRIVE
DRAPER, UTAH 84020-0289
(801) 452-4400

28 March 2011

Human Resources Office

SUBJECT: Submission of Bills to Department of Labor

In the past, it has been the policy of the Department of Labor, Office of Workers' Compensation Program (OWCP), to have care providers submit their bills to the agency whose federal employee sustained an injury. Care providers may now submit bills to the London, KY address listed below. It is not necessary for a care provider to register with the OWCP. Providers (excluding a pharmacy) must bill with their ACS OWCP provider number in box 33 of HCFA form 1500 or box 51 of UB-92. If the number is not on the form your bill will be returned. Prior approval for MRI's is no longer necessary, providing there is direct causal relationship to the work-related injury. For prior approval of surgery, please call (800) 218-1981 (FAX) or (866) 335-8319. If the claim is denied by Department of Labor, please call them at the toll number (850) 558-1818. Often it is an error in ICD9 coding, which should be obtained from the claimant, your registration number is missing, or the claimant's claim number was not included on the bill. Bills should also include medical records relating to the injury and a copy of the CA-16, which should be presented to you on the first visit (the original CA-16 should be returned to the individual). Please submit bills directly to the following:

U.S. DEPARTMENT OF LABOR
DFEC CENTRAL MAILROOM
PO BOX 8300
LONDON KY 40742-8300

Registration can be accomplished on-line at <https://owcp.dol.acs-inc.com>, or at **850-558-1818**, which will be a toll call. An OWCP case number must be on all submissions. This agency can provide the case number to you, as soon as it is available, which is normally within 10 working days after the injury.

You and your Care Provider can monitor bills at this site: <http://owcp.dol.acs-inc.com>

Right click and select open hyperlink

Agency
Claimant
Provider





Office of Workers Compensation Program

Form CA-16 Packet (Con't)

Return completed CA16 page 1 and 2
Completed CA 17 and any other documentation received from the
Medical Provider to ICPA Coordinator as soon as possible

REMINDER

Only a Medical Doctor
(M.D.) signature is
acceptable on all medical
documents



Office of Workers Compensation Program

Forms required for follow-up appointments

CA17 and CA20

**The employee must ensure that he/she has the
Medical Provider complete CA17 and CA20**

REMINDER

**Only a Medical Doctor
(M.D.) signature is
acceptable on all medical
documents**

Office of Workers Compensation Program

FOLLOW-UP VISITS

If an employee requires follow up visits, his/she must have in there possession CA-17 and CA20. Medical provider must complete there portion (reminder only a Medical Doctor (MD) signature is acceptable) on the above documents. Ensure ICPA Coordinator is provided a copy, documentation will be forward to Department of Labor for further processing

Duty Status Report Reset Print

U.S. Department of Labor
Office of Workers' Compensation Programs

This form is provided for the purpose of obtaining a duty status report for the employee named below. This request does not constitute authorization for payment of medical expense by the Department of Labor, nor does it invalidate any previous authorization issued in this case. This request for information is authorized by law (5 USC §101 et seq.) and is required to obtain or retain a benefit. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No. 1240-0048
Expires: 09-30-2011

OWCIP File Number (if known)

SIDE A - Supervisor: Complete this side and refer to physician

1. Employee's Name (Last, first, middle)
DOE, JOHN C

2. Date of Injury (Month, day, yr.)
01/22/2011

3. Social Security No.
123-45-6789

4. Occupation
SURFACE MAINTENANCE COORDINATOR

5. Describe How the Injury Occurred and State Parts of the Body Affected
While playing basketball a authorized Physical Activity, jumped and rolled right ankle.

6. The Employee Works
Hours Per Day 10:00 Days Per Week 4:00

7. Specify the Usual Work Requirements of the Employee. Check Whether Employee Performs These Tasks or is Exposed Continuously or Intermittently, and Give Number of Hours.

Activity	Continuous	Intermittent	His Per Day
a. Lifting/Carrying: State Max Wt.			
b. Sitting			
c. Standing			
d. Walking			
e. Climbing			
f. Kneeling			
g. Bending/Stooping			
h. Twisting			
i. Pulling/Pushing			
j. Simple Grasping			
k. Fine Manipulation (includes keyboarding)			
l. Reaching above Shoulder			
m. Driving a Vehicle (Specify)			
n. Operating Machinery (Specify)			
o. Temp. Extremes			
p. High Humidity			
q. Chemicals, Solvents, etc. (Specify)			
r. Fumes/Dust (Specify)			
s. Noise (Give dBA)			
t. Other (Describe)			

14. Are Interpersonal Relations Affected Because of a Neuropsychiatric Condition? (e.g. Ability to Give or Take Supervision, Meet Deadlines, etc.)
☐ Yes ☐ No (Describe)

15. Date of Examination

16. Date of Next Appointment

17. Specialty

18. Tax Identification Number

19. Physician's Signature

20. Date

Form CA-17
Rev. Jan. 1997

Record of Examination Submit Reset Print

Attending Physician's Report

U.S. Department of Labor
Office of Workers' Compensation Programs

1. Patient's name * Last First Middle
DOE, JOHN C

2. Date of injury * mo. day yr.
01/22/2011

3. OWCIP File Number
122679234

4. What history of injury (including disease) did patient give you?
While playing basketball a authorized Physical Activity, jumped and rolled right ankle.

5. Is there any history or evidence of concurrent or pre-existing injury or disease or physical impairment?
(If yes, please describe)
☐ Yes ☐ No

6. What are your findings? (Include results of X-Rays, laboratory reports, etc.)

7. What is your diagnosis?

ICD-9 Code *

8. Do you believe the condition found was caused or aggravated by an employment activity? (Please explain answer)
☐ Yes ☐ No

9. Did injury require hospitalization?
If no, go to item #23. ☐ Yes ☐ No

10. Date of admission mo. day yr.

11. Date of discharge mo. day yr.

12. Additional hospitalization required? (Item 25) ☐ Yes ☐ No

13. What treatment did you provide?

14. Date of first examination mo. day yr.

15. Date(s) of treatment mo. day yr.

16. Date of discharge from treatment mo. day yr.

17. Period of total disability From mo. day yr. To mo. day yr.

18. Period of partial disability From mo. day yr. To mo. day yr.

19. Date employee able to resume light work mo. day yr.

20. Date employee is able to resume regular work mo. day yr.

21. Have you been advised that you can return to work? ☐ Yes ☐ No

22. If yes, on what date was he/she advised? mo. day yr.

23. If employee is able to resume only light work, indicate the extent of physical limitations and the type of work that could reasonably be performed with these limitations. (Continue in item #25 if necessary.)

24. Are any permanent effects expected as a result of this injury? If yes, describe in item #25. ☐ Yes ☐ No

25. Remarks

26. If you have referred the employee to another physician provide the following:
Name
Address
City State ZIP
☐ Consultation ☐ Treatment

27. What was the reason for this referral?

Signature
28. I certify that the statements in response to the questions asked above are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statements or any misrepresentation or concealment of material fact which is knowingly made may subject me to criminal prosecution.
Signature of Physician Signature Date 03/28/2011

29. Name of Physician
30. Tax ID Number
31. Do you specialize? ☐ Yes ☐ No
32. If yes, indicate specialty

Form CA-20
Rev. Nov. 1996

Filing Claims using Electronic Data Interchange

- DoD Civilian Personnel Management Service
- Injury and Unemployment Compensation Division

EDI Electronic Data Interchange

- It has been DoD policy since July 2003 to utilize EDI when submitting claims
- DOL will be monitoring agency timeliness for claim submission as a result of POWER
- Defense Safety Oversight Council (DSOC) will be monitoring DoD agency timeliness and use of EDI for claim submission



Office of Workers Compensation Program

Safety First Electronic Reporting (SAFER)

- DOL has made a determination as to which claim data can be shared with an organization's safety office in order to assist in fulfilling OSHA reporting requirements
- EDI/SAFER provides the data to safety in the form of an OSHA 301 notice. This 301 notice provides safety with the data they need to start their reporting and investigations

EDI INFORMATION FLOW

- Employee reports the injury to his/her supervisor
- Supervisor and employee complete the electronic form, which is transmitted to the ICPA. Supervisors do not need any special access to file the claim electronically, only a computer with internet access
- Supervisor prints completed CA1

EDI INFORMATION FLOW

- Injured employee and supervisor sign the printed copy of CA1
- Supervisor electronically submits claim for processing
- ICPA receives an email notification of the claim submission
- IPCA will review and enters appropriate codes and corrects any errors. If there is an error a corrected copy of CA1 will be sent to supervisor and injured employee for

EDI INFORMATION FLOW

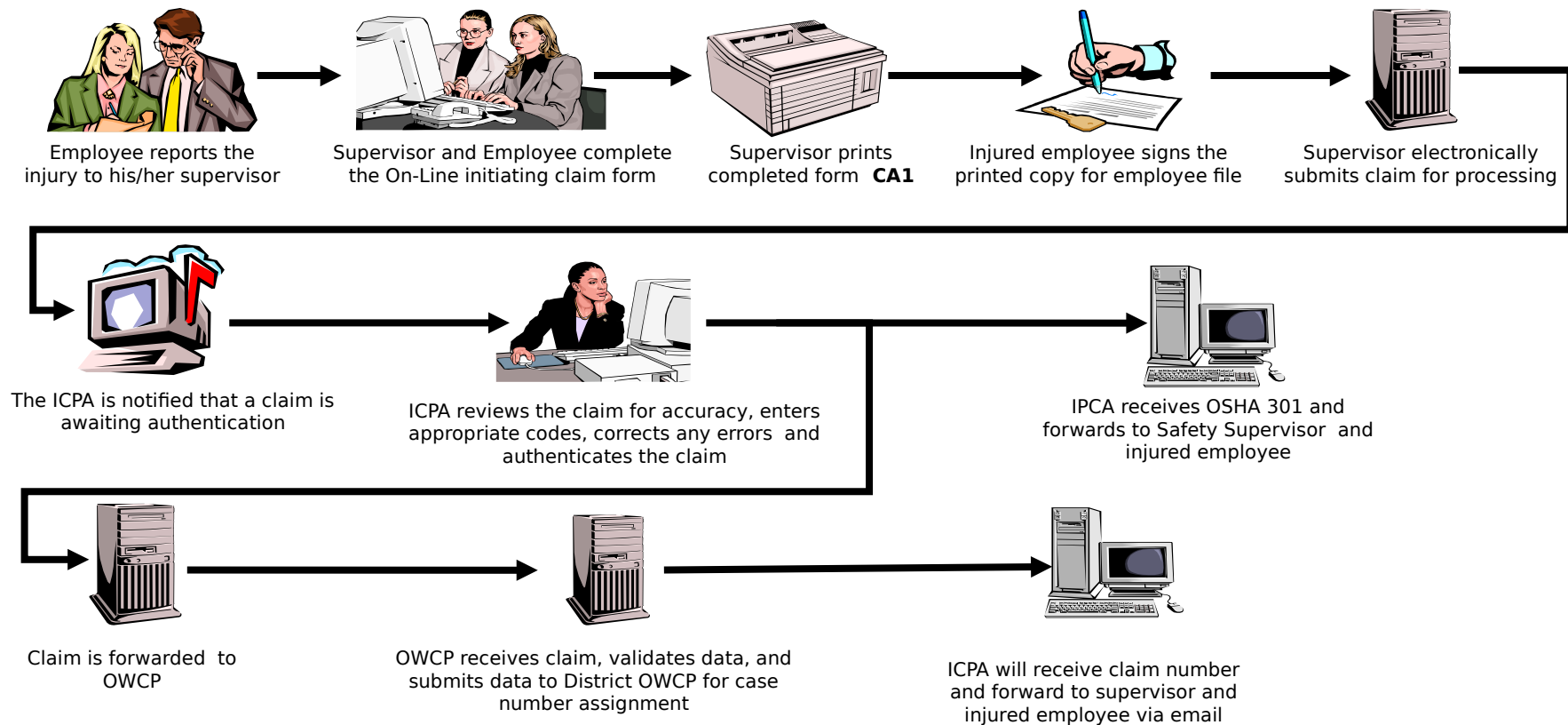
- IPCA will then forward claim to OWCP
- IPCA will receive, via email, a copy of the OSHA 301 and forward to the appropriate Safety Office, injured employee and supervisor via email
- OWCP receives claim, validates data and submits data to District OWCP for a claim number assignment

EDI INFORMATION FLOW

- ICPA will receive an email with the claim number within 2-3 business days and provide the injured employee and supervisor the claim number via email
- It is the injured employee responsibility to provide the medical provider the claim number for billing purposes

Office of Workers Compensation Program

EDI - Electronic Data Interchange





Office of Workers Compensation Program

On-line CA-1/CA-2

**NO hand written, typed or emailed CA-1 or
CA-2 will be accepted
ALL CA-1 and CA-2 must be done
electronically**

<http://www.cpms.osd.mil/icuc>

Office of Workers Compensation Program



ICUC Division

Injury and Unemployment Compensation Division

- ▶ About Injury Compensation
- ▶ About Unemployment Compensation
- ▶ **Filing Claims Electronically** (supervisor's links)
- ▶ DIUCS SSO (password required)
- ▶ DEFPAC (password required)
- ▶ ICUC Distance Learning Program
- ▶ DoD Civilian



[CPMS Web Policies & Links](#)

Welcome to ICUC

[CPMS Home](#) < [ICUC](#)

Hot Topics

Updates to CA-7 Processing System

The Injury & Unemployment Compensation Division has been advised by the Department of Labor (DOL) that updates have been made to the CA-7 processing system. There are several new claim statuses that can be viewed in the Agency Query System (AQS). [»More](#)

Claimant Query System (CQS) User Guides

The Injury & Unemployment

Products & Services

- DoD Pipeline Program
- Filing Injury Claims Electronically
- Training Opportunities
- Liaison Services
- Injury Compensation (IC)
- What is DeFPAC?
- Unemployment Compensation (UC)
- ICUC Systems Access Request

Office of Workers Compensation Program

Disclaimer

This DoD computer system including all related equipment, networks, and network devices (specifically including internet access), is provided only for authorized U.S. Government use. DoD computer systems may be monitored for all lawful purposes, including to ensure authorized use, for system management, to facilitate protection against unauthorized access, and to verify security procedures, survivability and operational security. Monitoring includes active attacks by authorized DoD entities to test or verify the security of this system. During monitoring, information may be examined, recorded, copied and used for authorized purposes. All information, including personal information, placed on or sent over this system may be monitored. Use of this DoD computer system, authorized or unauthorized, constitutes consent to monitoring. Unauthorized use may subject you to criminal prosecution. Evidence of unauthorized use collected during monitoring may be used administrative, criminal or other adverse action.

OK

Cancel

EDI/SaFER V1.35 07/26/06

Select OK in order to access the application

Office of Workers Compensation Program

Supervisor Entry

Enter A New U.S. Department of Labor Worker's Compensation Claim Form:

Claimant

Social Security Number (SSN):

Date of Birth (MM/DD/YYYY):

When the initial claim entry screen appears, the employee's SSN and DOB will be entered and type of claim form will be selected

Claim Form Type

☒ CA-1 Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay / Compensation

☐ CA-2 Notice of Occupational Disease and Claim for Compensation

Enter claim

Exit

EDI/SaFER V1.35 07/26/06

Select Enter Claim

Office of Workers Compensation Program

DIUCS v2.1 EDI

Window

ORACLE

EDI CA1

Emp. Data

Injury

Emp. Signature

Witness

Sup Rpt 1

Sup Rpt 2

Sup Rpt 3

Sup Rpt 4

Safety Data

Sup Signature

1. Name of employee

Last Name: SMITH

First Name: JOHN

Middle Name:

Suffix:

(not entered)

2. Social Security Number

111-11-1111

3. Date of birth

MM-DD-YYYY

01-01-1960

4. Sex

☒ Male

☐ Female

5. Home Phone

(123) 455-7890

6. Grade as of date of injury

Level: WG10

Step: 05

7. Employee's home mailing address

Street Address:

City:

State:

ZIP Code:

8. Dependents

☒ Wife, Husband

☒ Children under 18 years

☐ Other

Claim information

EDI claim number:

Status:

Some fields require the data entered to be in a particular format. For example, phone numbers should be entered without using

- White fields are required to be filled in
- Yellow fields are optional and do not have to be filled in
- Gray fields are informational and cannot have data entered into

Check both blocks if married and have children under 18

Office of Workers Compensation Program

DIUCS v2.1 EDI

Window

ORACLE

EDI CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

1. Name of employee

Last Name: SMITH First Name: JOHN

Middle Name: Suffix: (not entered)

2. Social Security Number

111-11-1111

3. Date of birth MM-DD-YYYY

01-01-1960

4. Sex

☒ Male ☐ Female

5. Home Phone

(123) 455-7890

6. Grade as of date of injury

Level: WG10 Step: 05

7. Employee's home mailing address

Street Address:

City:

State: ZIP Code:

8. Dependents

☐ Wife, Husband

☐ Children under 18 years

☐ Other

Claim information

EDI claim number: Status:

Trading partner ID: FECAEDI Status time:

FM-40209: Field must be of form FM9999999999999999.

Record: 1/1

Warning: Applet window

If data is entered into a field using the wrong format, the application will not let the user move forward until the data is correctly entered. A message will be provided at the bottom of the screen to inform the user as to what needs to be done to fix the format problem.

Office of Workers Compensation Program

DIUCS v2.1 EDI

Window

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)
MAIN OFFICE BUILDING, 1223445 WORK STREET, ANYTOWN FL
FLEMING ISLAND FL ZIP Code: 32006

10. Date & time injury occurred
MM-DD-YYYY HH:MM [AM|PM]
01-20-2005 02:30 PM

11. Date of this notice
MM-DD-YYYY
01-20-2005

12. Employee's Occupation Description
MAIL CLERK

13. Cause of injury (Describe what happened and why)
I WAS WALKING DOWN THE STAIRS AND I TRIPPED AND FELL

a. Occupation code
Cause of injury code

14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg)
BROKEN NOSE, BRUISED RIBS

The date you have entered the EDI system to create CA1

The employee's information will be entered into the system. Pay particular attention to fields that require a date and time such as Block 10. If no time is entered in the block, the time will default to 12:00 am.

DO NO USE MILITARY TIME



Office of Workers Compensation Program

Block 13 Cause of Injury

NOT SO GOOD

- While walking between the maintenance shops, I slipped on an icy surface and fell backwards and landed on my back

GOOD

- I was acquiring parts for the job order for the front end loader, I had to walk from the wash rack to the parts rack which is located outside the building. Due to snow and ice in and around the area I slipped and fell injuring my lower back



Office of Workers Compensation Program

Block 13 Cause of Injury

NOT SO GOOD

- ▣ I was playing basketball and hurt my ankle

GOOD

- ▣ I was playing basketball a authorized sport physical activity. I jumped for the ball and landed on someone else's foot and rolled my left ankle



Office of Workers Compensation Program

Block 14 Nature of Injury

NOT SO GOOD

- ▮ Ankle
- ▮ Right finger
- ▮ Cut on head

GOOD

- ▮ Sprain right ankle
- ▮ Smashed right index finger
- ▮ Laceration on left side of head

Office of Workers Compensation Program

DIUCS v2.1 EDI

Window

EDI_CA1

Emp. Data | Injury | **Emp. Signature** | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☒ a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.

☐ b. Sick and/or Annual Leave

☐ c. Unknown

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf _____ Date 01-20-2005

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records

The employee then elects whether to use Continuation of Pay and enters the date that the claim is being entered into the EDI application

Record: 1/1

Warning: Applet Window

Office of Workers Compensation Program

The screenshot shows a web browser window titled "DIUCS v2.1 EDI" with the Oracle logo in the top right. The address bar shows "Window". Below the browser window is a tabbed interface for "EDI_CA1". The tabs are: "Emp. Data", "Injury", "Emp. Signature", "Witness" (highlighted with a red box), "Sup Rpt 1", "Sup Rpt 2", "Sup Rpt 3", "Sup Rpt 4", "Safety Data", and "Sup Signature". The "Witness" tab is active, displaying the text "16. Statement of witness (Describe what you saw, heard, or know about this injury)". Below this text is a large yellow rectangular area intended for the witness statement. A blue arrow points to the bottom-left corner of this yellow area.

- **Enter a witness statement in this space**
- **The witness will sign the statement when the claim form is printed**
- **If there is no statement, leave this space blank**
- **If the statement will not fit into the space annotate "witness statement forwarded under separate cover" in this space and fill out the witness information**
- **Send the separate signed witness statement to the ICPA**

Office of Workers Compensation Program

DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data Injury Emp. Signature Witness **Sup Rpt 1** Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

17. Agency name and address of reporting office

Agency name: GOVERNMENT AGENCY

Street Address: 123 WORK STREET

City: ANYTOWN

State: FL ZIP Code: 32006

OWCP Agency Code Charge Back CCPO

OSHA Site Code

OWCP District Office #

18. Employee's duty station

Street Address: GOVERNMENT AGENCY

City: ANYTOWN

State: FL ZIP Code: 32006

19. Employee's retirement coverage

☐ CSRS ☒ FERS ☐ OTHER (identify)

20. Regular work hours

HH:MM [AM|PM]

From: 09:00 AM To: 05:30 PM

21. Regular work schedule

☐ Sun. ☒ Mon

22. Date of injury

MM-DD-YYYY

01-20-2005

23. Date notice received

MM-DD-YYYY

01-20-2005

24. Date of injury

MM-DD-YYYY HH:MM [AM|PM]

01-20-2005

Enter the required information in the appropriate fields. Paying attention to the format for data entry

DO NO USE MILITARY TIME

The date the employee notified supervisor of injury

Office of Workers Compensation Program

DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 **Sup Rpt 2** Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

25. Date pay stopped
MM-DD-YYYY
[Yellow box]

26. Date 45 day period began
MM-DD-YYYY
[Yellow box]

27. Date & time employee returned to work
MM-DD-YYYY HH:MM [AM|PM]
[Yellow box]

28. Was employee injured in performance of duty?
☒ Yes ☐ No (If "No", explain)

If the supervisor does not believe the employee was injured in performance of duty, "no" should be checked and the facts that support that position should be provided . Otherwise leave the box checked "yes."

If the supervisor believes that willful misconduct was involved, "yes" should be checked and the facts that support this position provided. Otherwise leave the box checked "no"

Record: 1/1

Warning: Applet Window

Office of Workers Compensation Program

DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 **Sup Rpt 3** Sup Rpt 4 Safety Data Sup Signature

30. Was injury caused by third party?

☐ Yes
☒ No

31. Name and address of third party (include city, state, and ZIP code)

3rd party name:

name continued:

Street Address:

City:

State: ZIP Code:

32. Name and address of physician first providing medical care (Include city, state, and ZIP code)

Last Name

First Name

Street Address:

City:

State:

ZIP Code:

33. First date medical care received

MM-DD-YYYY

33a. Provided by Agency medical facility?

☐ Yes ☒ No

34. Do medical records show employee is disabled for work?

☐ Yes ☐ No ☒ Unknown

Example of a third party claims would be an automobile accident in which the other driver was

You should not have employee's medical records due to the HEPPA act

CHECK

If the individual was treated at an agency facility the information in Block 32 must be provided (unique to EDI/SAFER)

Office of Workers Compensation Program

DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 **Sup Rpt 4** Safety Data Sup Signature

35. Does your knowledge of the fact about this injury agree with statements of the employee and/or witness?

☒ Yes ☐ No (If "No", explain)

If the agency wishes to challenge the claim, then "no" must be selected for this item and the reasons for the challenge entered into this space

36. If the employing agency controverts continuation of pay, state the reason in detail.

Enter the reason for the controversion of COP in this space.

37. Pay rate when employee stopped work

Amount: Per:

Record: 1/1

Warning: Applet Window

Office of Workers Compensation Program

DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 **Safety Data** Sup Signature

Work Environment Exceptions

- ☐ Employee was member of general public rather than an employee at the time of injury.
- ☐ Injury resulted from non-work related event or exposure occurring outside of the work environment.
- ☐ Injury resulted from voluntary participation in a wellness program or in a medical, fitness, or recreational activity.
- ☐ Injury resulted from employee eating, drinking, or preparing food or drink for personal consumption.
- ☐ Injury resulted from personal grooming, self medication, or was intentionally self-inflicted.
- ☐ Injury resulted from a motor vehicle accident occurring on company premises while commuting to or from work.
- ☐ Injury is the common cold or flu.

Physical Training

Privacy Case Status:

A

Not A Privacy Case

Using CTRL+L when the cursor is placed in the Privacy Case Status field will display the listing of values for that field

General Recording Criteria

- ☐ Employee is deceased as a result of the incident.
- ☐ Employee suffered days away from work as a result of the incident.
- ☐ Employee's work activity was restricted as a result of the incident.
- ☒ Employee was treated in an emergency room as a result of the incident.
- ☐ Employee was hospitalized overnight as an in-patient.
- ☐ Employee lost consciousness as a result of the incident.
- ☐ Employee was transferred to another job as a result of the incident.

29 CFR 1904:

RECORDABLE

OSHA 300 Log Coding:

J,1

Injury Classification:

A

Injury

As Of:

01-20-2005 02:53:38 PM

Check all that apply for the sections on this tab. Information will be used to generate the OSHA 301 notice used for safety notification

Office of Workers Compensation Program

DIUCS v2.1 EDI

Window

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | **Sup Signature**

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

YOU CAN ADD ANY ADDITIONAL INFORMATION IN THIS BLOCK

Was an on-site investigation conducted?

☐ Yes ☒ No

What was the root cause of this injury?

Last Name: SUPERVISOR First Name: JOE

Name of Supervisor: SUPERVISOR

Signature of supervisor: _____ Date signed: MM-DD-YYYY 01-20-2005

Supervisor's Title: SUPERVISOR Supervisor's Email Address: jsupv@govt.mil Supervisor's Office phone number: 1234567890

39. Filing Instructions

☐ No lost time and no medical expense: Place this form in employ

☒ No lost time, medical expenses incurred or expected: forward th

☐ Lost time covered by leave, LWOP, or COP: forward this form to

☐ First Aid Injury

Email Validation

Please re-type your email address here, before you can continue, then press OK.

jsupv@govt.mil

OK

View Claim **Submit Claim** **Cancel** **Exit**

Select the appropriate filing instructions

Enter supervisor's email

The system will then have you re-enter for in order to validate

Office of Workers Compensation Program

DIUCS v2.1 EDI

Window

ORACLE

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data **Sup Signature**

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

YOU CAN ADD ANY ADDITIONAL INFORMATION IN THIS BLOCK

Was an on-site investigation conducted?



Yes



No

What was the root cause of this injury?

Last Name

First Name

Middle Name

Name of Supervisor: SUPERVISOR

JOE

MM-DD-YYYY

Signature of supervisor: _____

Date signed: 01-20-2005

Supervisor's Title

Supervisor's Email Address:

Supervisor's Office phone number

SUPERVISOR

jsupv@govt.mil

1234567890

39. Filing Instructions

- ☐ No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
- ☒ No lost time, medical expenses incurred or expected: forward this form to OWCP
- ☐ Lost time covered by leave, LWOP, or COP: forward this form to OWCP
- ☐ First Aid Injury

Select the View Claim button

View Claim

Exit

Record: 1/1

Warning: Applet Window

Office of Workers Compensation Program

DIUCS v2.1 EDI

Window

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data **Sup Signature**

The View Claim for Printing and Submit to ICPA option allows the claim to be viewed and printed as a .pdf file and then sent to the ICPA without any further action by the user.

The View Draft Copy of Claim to Verify Data option allows the claim to be viewed and printed as a .pdf file but the user must then select the Submit Claim button to send the claim to the ICPA.

Signature of Supervisor: _____ Date signed: 07/10/2008

Supervisor's Title: SUPERVISOR Supervisor's Email Address: supv@agency.gov Supervisor's Office phone number: 1234567890

Required Submission

What would you like to do?

View Claim for Printing and Submit to ICPA

View Draft Copy of Claim to Verify Data

View Claim Submit Claim Cancel Exit

Record: 1/1

Once the View Claim button is selected, a dialog box will open providing two options

Office of Workers Compensation Program

Acrobat Reader - [rwservlet[2].pdf]

File Edit Document Tools View Window Help

Review the claim. If the information is correct, select the print icon and print the claim. The employee, supervisor, and witness should then sign their portion. The signed copy is forwarded to the ICPA for record retention.

Federal Employee's Notice of Traumatic Injury and Claim for Continuation Pay/Compensation
Employee: Please complete all boxes 1 - 15 below. Do not complete section 16.
Witness: Complete bottom section 16.
Employing Agency (Supervisor or Compensation Specialist): Complete section 17.

Employee Data

1. Name of Employee (Last, First Middle Suffix)			SMITH JOHN		11111111	
3. Date of Birth	4. Sex	5. Home Telephone		6. Grade as of date of injury		
01/01/1960	MALE	123456789		Level WG10 Step 05		
7. Employee's home mailing address (include city, state, and ZIP code)				8. Dependents		
123 MAIN STREET ANYTOWN FL 32006				<input type="checkbox"/> Wife/Husband <input type="checkbox"/> Children under 18 year <input type="checkbox"/> Other		
Description of Injury						
9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine) MAIN OFFICE BUILDING, 1223445 WORK STREET, ANYTOWN FL FLEMING ISLAND FL						
10. Date injury occurred		11. Date of this notice		12. Employee's job title		
01/20/2005 02:30 PM		01/20/2005		MAIL CLERK		
13. Cause of injury (Describe what happened and why) I WAS WALKING DOWN THE STAIRS AND I TRIPPED AND FELL						

1 of 8 10 x 11 in

Office of Workers Compensation Program

DIUCS v2.1 EDI

Window

ORACLE

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data **Sup Signature**

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

YOU CAN ADD ANY ADDITIONAL INFORMATION IN THIS BLOCK

Was an on-site investigation conducted?



Yes



No

What was the root cause of this injury?

Last Name

First Name

Middle Name

Name of Supervisor: SUPERVISOR

JOE

MM-DD-YYYY

Signature of supervisor:

Date signed: 01-20-2005

Supervisor's Title

Supervisor's Email Address:

Supervisor's Office phone number

SUPERVISOR

jsupv@govt.mil

1234567890

39. Filing Instructions

- ☐ No lost time and no medical expense: Please
☒ No lost time, medical expenses incurred or
☐ Lost time covered by leave, LWOP, or CC
☐ First Aid Injury

View Claim

Submit

If the View Draft Copy of Claim to Verify Data option was selected, the Submit Claim button must be selected on order to transmit the claim to the ICPA

FRM-40400: Transaction complete: 1 records applied and saved.

Record: 1/1

Warning: Applet Window



Office of Workers Compensation Program

SUMMARY OF SUPERVISOR ACTIONS IN COMPLETING

CA1

- Supervisor accesses the EDI application through the “Filing Claims Electronically” link on the ICUC Web page
- Supervisor enters the SSN and Date of Birth of the employee and selects whether a CA-1 or CA-2 will be filed
- Employee information is entered onto the form
- Witness information is entered (if applicable)
- Supervisor enters required information in supervisors portion of the form
- The form is printed
- The employee, witness and supervisor sign their respective sections
- “Submit Claim” button is selected and claim is sent electronically to the ICPA
- Signed claim form is sent to the ICPA to be retained in the file

TIMELINESS

Federal agencies are required by regulation to submit an employee's Notice of Injury (Form CA-1 or CA-2) CA-16, CA-17 and all supporting documentation within 10 working days (or 14 calendar days) of receiving notice of injury from an employee. Supervisor will ensure the following documentation is complete and sent to IPCA Coordinator for further processing.

Required documentation that must be sent to the IPCA

- CA-1 Federal Employee's Notice of Traumatic Injury and Claim for Continuation Pay/Compensation
 - ✓ Ensure block 15 is signed by employee or person acting on his/her behalf
 - ✓ Ensure block 16 is signed if there was a witness statement
- CA-16 Authorization for Examination And/Or Treatment
 - ✓ Supervisor must complete block 8&9
 - ✓ Block 35 must be signed by a Medical Doctor (MD)

Required documentation that must be sent to the IPCA

- CA-17 Duty Status Report
 - ✓ Block 19 must be signed by a Medical Doctor (MD)
 - ✓ CA-17 informs the Supervisor of any limitations the employee may have and if the employee is to be placed on light duty or Continuation of Pay (COP)
- And any other supporting documentation received from Medical Provider

REMINDER

Only a Medical Doctor (M.D.)
signature is acceptable on all
medical documents



Office of Workers Compensation Program

Supervisor OWCP Checklist

See Handout

Continuation of Pay (COP)

COP is payable for a maximum of 45 calendar days

Employee was injured on November 1 and was coded LU and returned to work on November 2. Medical Provider stated on CA-16 and CA-17 that the employee follow-up November 6. Medical Provider restricted employee from returning to work until November 8 and on November 9 employee was returned to work with no restrictions.



Office of Workers Compensation Program

Sun	Mon	Tue	Wed	Thu	Fri	Sat
NOVEMBER			Date of Injury Admin Leave 1	COP CAN BEGIN CODE LT 2	3	4
5	R Code LT 6	7 Code LT	Code LU Code LT 8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		63



Office of Workers Compensation Program

Sun	Mon	Tue	Wed	Thu	Fri	Sat
DECEMBER					1	2
3	R 4	5	6	7	8	9 1
10	11	12	13	14	15	45 Day 16
17	18	19	20	21	22	23
<u>24</u>	25	26	27	28	29	30
31						64

Continuation of Pay (COP)

See Handout

LIGHT DUTY

Responsibility of...

- ✦ the supervisor to try to accommodate the return of an employee on light duty
- ▮ the HRO to officially reassign an employee to another position if necessary
- ▮ the employee to cooperate



LIGHT DUTY POLICY

Placing Technicians on Light Duty
(TN-11-02) as per the direction of
NGB

See Handout

LIGHT DUTY POLICY MEMORANDUM

See Handout

Physical Fitness Agreement

See Handout

QUESTIONS & ANSWERS